Special Olympics Arizona

MEDICAL RELEASE FORM

SOAZ USE ONLY:
- ☐ New Athlete
- ☐ Recorded in GMS
- ☐ Initial _____

Delegation/Program Name: _____

Area #: ___ ___ **Program #:** ___ ___ ___

Please print clearly and complete **all** sections in their entirety
This application expires three (3) years from the date of physical exam

SECTION A: DEMOGRAPHICS

Athlete Name:	☐ Male ☐ Female Date of Birth (month/date/year) : / /
Athlete Address:	Athlete Age:
Apt#	Athlete Home Phone: ( )
City: State: Zip:	Parent Primary Phone: ( )
Parent/ Guardian Name:	Athlete E-mail:
Parent/Guardian Address (if different than athlete):	Parent E-mail:
City: State: Zip:	Emergency Contact Phone: ( )
Health/Accident Insurance Company:	Emergency Contact (if other than Parent/Guardian):
Policy#:	Primary Language:
Ethnic Background (optional) Solely to help us comply with government record keeping, reporting, and other legal requirements, please check your ethnicity to the right →	❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Native Hawaiian or Other Pacific Islander ❑Latino/Hispanic ❑White

SECTION B: HEALTH HISTORY (MAY BE COMPLETED BY PARENT/CAREGIVER/ADULT ATHLETE)
PLEASE INDICATE "YES" OR "NO" FOR ALL AREAS

Yes	No		Yes	No	
☐	☐	Allergies to Medicine: _____	☐	☐	Requires Constant Supervision
☐	☐	Allergies to Food: _____	☐	☐	Hearing Loss/Hearing Aid
☐	☐	Allergies to Stings/Bites: _____	☐	☐	Heart Disease/Heart Defect/High Blood Pressure
☐	☐	Allergies to Other: _____	☐	☐	Heat Stroke/Exhaustion
☐	☐	Special Diet: _____	☐	☐	Immunizations up-to-date
☐	☐	Blindness/Visual Problems (other than corrective lenses)	☐	☐	Major Surgery or Serious Illness
☐	☐	Bone or Joint Problem	☐	☐	Autism
☐	☐	Chest Pain	☐	☐	Seizures/Epilepsy/Fainting Spells
☐	☐	Concussion or Serious Head Injury	☐	☐	Sickle Cell Trait or Disease
☐	☐	Contact Lenses/Glasses	☐	☐	Asthma
☐	☐	Diabetes	☐	☐	Uses Tobacco
☐	☐	Shunts	☐	☐	Uses Wheelchair
☐	☐	Easy Bleeding	☐	☐	Other:
☐	☐	Emotional/Psychiatric/Behavioral Problems			_____
☐	☐	Non-Verbal – If yes, alternate form of communication:			

Date of most recent tetanus immunization: _____/_____/_____

Is the athlete taking any prescription medications? Yes ☐ No ☐ If yes, please list all medications below.

**All changes in medication should be submitted to Special Olympics Arizona. For more space, please attach additional paper.

Medication Name	Dosage	Date Prescribed	Times per day	Medication Name	Dosage	Date Prescribed	Times per day
1)				4)			
2)				5)			
3)				6)			

SIGNATURE OF PERSON COMPLETING THIS FORM (PARENT/CAREGIVER/ADULT ATHLETE):

_____ ____ /____ /_____ _____

Signature **Date** **Printed Name**

SECTION C: ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

Does the athlete have Down Syndrome? Yes ☐ No ☐ **If yes, you must complete the area below.**

The **sports and events for which such a radiological examination is required and the Special Release Form C-3 completed** are: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and football team competition (soccer).

PLEASE CHECK THE FOLLOWING:

Yes	No	
☐	☐	Does the athlete participate in a restricted sport or event? If yes or unknown, an x-ray for atlanto-axial instability must be done.
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done? **Please provide X-Ray Date:** _____
☐	☐	If yes, was the x-ray positive for atlanto-axial instability? Positive indication is the atlanto-dens interval is 5mm or more.

SECTION D: PHYSICAL EXAMINATION (MUST BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL)

Blood Pressure: /

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
☐	☐	Vision	☐	☐	Cardiovascular system	☐	☐	Cranial nerves
☐	☐	Hearing	☐	☐	Respiratory system	☐	☐	Coordination
☐	☐	Oral cavity	☐	☐	Gastrointestinal system	☐	☐	Reflexes
☐	☐	Neck	☐	☐	Genitourinary system			
☐	☐	Extremities	☐	☐	Skin			

Weight:

Height:

Other:

Primary MR Etiology/Category (if known):

☐ Yes ☐ No I have reviewed the above health information and have performed the above examination on this athlete within the past six (6) months and certify that the athlete can participate in Special Olympics.

Sport Restrictions:

Examiner's Signature (required): **Date of Exam (required):** / /

Examiner's Name:
Print legibly or stamp

Clinic Name: Address (City, State, Zip):

Phone: ( )

The following should keep copies of this form: 1) The State Office 2) The Delegation/Program 3) The Head Coach 4) Athlete's Parent/Legal Guardian

ALL COACHES WILL BE RESPONSIBLE FOR HAVING UP-TO-DATE ATHLETE MEDICAL FORMS IN THEIR POSSESSION AT TRAINING AND COMPETITION EVENTS AND DURING TRANSPORTATION AND TRAVEL. RETAIN COPIES FOR LOCAL, AREA AND PERSONAL RECORDS.

REV: 8/2009

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

Special Olympics Arizona

Delegation/Program Name: _____ **Area #:** ___ ___ **Program #:** ___ ___ ___

Athlete's Name: Last:_____ **First:**_____ **D.O.B.:** ___/___/____

RELEASE TO BE COMPLETED BY PARENT/GUARDIAN OR ADULT ATHLETE (OWN GUARDIAN)

I, the Parent/Guardian or Adult Athlete submits this Official Special Olympics Release Form for participation in Special Olympics.

Section 1
I represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in the application for participation and has certified, based on a medical examination, that there is no medical evidence which would preclude the athlete from participating in Special Olympics.

Section 2
I understand that if the athlete has Down syndrome, the athlete cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine unless the athlete and physician have completed the official "Down syndrome Addendum Form", available from the Special Olympics State Office. I am aware that the x-ray exam is required before any athlete with Down syndrome may participate in equestrian, gymnastics, judo, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and soccer.

Section 3
Special Olympics has my permission, both during and anytime after, to use the athlete's likeness, name, voice or words in either television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

Section 4
If during the athlete's participation in Special Olympics activities, the athlete should need emergency medical treatment, and I (the parent/guardian or adult athlete) am not able to give consent or make arrangements for that treatment, I authorize Special Olympics to take whatever measures necessary to protect the athlete's health and well-being, including if necessary, hospitalization.

Section 5
I understand by signing below, that I consent to participate in the **Special Olympics Healthy Athletes Program** that provides individuals screening assessments of health status and health care needs in the areas of vision, oral health, hearing, physical therapy, and a variety of health promotion areas. I understand there is no obligation for the athlete to participate in the Healthy Athletes Program and that the athlete may decide not to participate. Provisions of these health services are not intended as a substitute for regular care. I also understand that I should seek independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not responsible for the health of the athlete. I understand that information gathered as part of the screening process may be used anonymously to assess and communicate overall health and needs of athletes and to develop programs to address those needs.

To be completed by Adult Athlete (own Guardian)

I, the adult athlete, have read this form and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature _____

Print Name _____

Date: _____/_____/_____

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Signature _____

Print Name _____

Date: _____/_____/_____

OR

To be completed by Parent/Guardian

I, the Parent/Guardian of this athlete, hereby give my permission for this athlete to participate in Special Olympics games, training, recreation programs, physical activity programs and Healthy Athletes program. By signing, I am saying that I agree to the provisions of this release.

Signature _____

Print Name _____

Date: _____/_____/_____

THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED, AND DATED TO BE CONSIDERED VALID FOR THREE (3) YEARS

Created by The Joseph P. Kennedy, Jr. Foundation for the Benefit of Citizens with Intellectual Disabilities REV: 8/2009

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